STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151595	A. BUILDING _____ B. WING _____	02/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASERACARE HOSPICE	**332 W US HWY 30 STE E VALPARAISO, IN 46385**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was a Hospice state complaint investigation survey. Complaint number: IN00102497 - Unsubstantiated: Lack of suficient evidence. Survey date: February 24, 2012 Facility number: 011201 Medicaid vendor number: 200519300B Surveyor: Bridget Boston, RN, Public Health Nurse Surveyor Aseracare Hospice was found to be in compliance with IC 16-25-3-4 version b which by reference includes 42 CFR 418.20 Eligibility requirements, 418.22 Certification of terminal illness, 418.24 Election of hospice care, 418.25 Admission to hospice care, and 418.26 Discharge from hospice care as were related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN March 2, 2012	S 000		